PEARSON
Chiropractic & Rehabilitation Center

MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name ______________________ Today's Date ____________

General Information

DATE OF ACCIDENT	☐ Patient was the driver—seated in driver's seat			
____ / ____ / ____	☐ Patient was a passenger	Location: ☐ Front Seat	☐ Middle Seat	☐ Back Seat
		Position: ☐ Left Side	☐ Middle	☐ Right Side

PATIENT'S VEHICLE		
	Type	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other ______
	Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Action	☐ Stopped ☐ Slowing ☐ Accelerating ☐ Cruising
	Speed (MPH)	Number of other people in your vehicle
	Time of Accident	☐ Dawn ☐ Daylight ☐ Dusk ☐ Dark
	Road Conditions	☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice
	Visibility	☐ Good ☐ Fair ☐ Poor
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure $ ______
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other ______

Enter impact information for up to three vehicles or objects.

Impact #1 Information: Object or Vehicle

☐ Object	Name of Object	
☐ Vehicle	Vehicle Type	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other ______
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other ______

Impact #2 Information: Object or Vehicle

☐ Object	Name of Object	
☐ Vehicle	Vehicle Type	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other ______
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other ______

Impact #3 Information: Object or Vehicle

☐ Object	Name of Object	
☐ Vehicle	Vehicle Type	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other ______
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other ______

During Impact Information

Was your seat belt on?	☐ Yes	☐ No	Were the brakes applied?	☐ Yes	☐ No
Did the airbag deploy?	☐ Yes	☐ No	Was your seat broken?	☐ Yes	☐ No
Did your seat back position change?	☐ Yes	☐ No	Did you hit your head?	☐ Yes	☐ No

During Impact Information continued

Head rest position:	☐ Low ☐ Medium ☐ High ☐ No head rest
Did you prepare for the accident?	☐ Unexpected ☐ Expected ☐ Expected and braced
What was your body position?	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other ____________
Was your body thrown during the accident?	☐ Yes ☐ No
Head position at the time of the accident	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other ____________
Did you lose consciousness? ☐ Yes ☐ No	For how long?

Body Impact Information

☐ Head ☐ Left Shoulder ☐ Left Arm ☐ Left Elbow ☐ Left Hand

☐ Upper Front Torso ☐ Upper Back ☐ Left Leg ☐ Right Leg ☐ Right Shoulder

☐ Right Arm ☐ Right Elbow ☐ Right Hand ☐ Mid Torso ☐ Mid Back

☐ Right Knee ☐ Left Knee ☐ Lower Front Torso ☐ Lower Back ☐ Right Foot

☐ Left Foot ☐ Other ____________

After Accident Information

Were the police notified? ☐ Yes ☐ No

Immediately after the accident, how did you feel? ☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Other ____________

PAIN: (Indicate if you experienced any pain in these areas immediately following the accident)

☐ Head ☐ Neck ☐ Left Shoulder ☐ Left Arm ☐ Left Elbow

☐ Left Hand ☐ Upper Front Torso ☐ Upper Back ☐ Left Leg ☐ Right Leg

☐ Right Shoulder ☐ Right Arm ☐ Right Elbow ☐ Right Hand ☐ Mid Torso

☐ Mid Back ☐ Right Knee ☐ Left Knee ☐ Lower Front Torso ☐ Lower Back

☐ Right Foot ☐ Left Foot ☐ Other ____________

NUMBNESS: (Indicate if you experienced any numbness in these areas immediately following the accident)

☐ Left Hand ☐ Right Hand

☐ Left Leg ☐ Right Leg

☐ Left Upper Arm ☐ Right Upper Arm

☐ Left Foot ☐ Right Foot

☐ Other ____________

Medical Care

Did you get medical care for this accident before coming to our office? ☐ Yes ☐ No

Time of care	☐ Immediately ☐ Later that day ☐ Next day ☐ Days later: Number of days______
Transported by	☐ Drove myself ☐ Ambulance ☐ Other ____________
Type of doctor you saw	☐ Orthopedist/Chiropractor ☐ Neurologist ☐ Family Doc ☐ ER ☐ Other ____________
Admitted to the hospital?	☐ Yes ☐ No
Tests performed	☐ X-Ray ☐ Lab work ☐ MRI ☐ CT Scan ☐ Other ____________
Treatment given	☐ Ice Pack ☐ Hot Pack ☐ Cervical Collar ☐ Medication ☐ None ☐ Other ____________

Previous Injuries

Have you suffered previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: ____________

Do you have residual pain from previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: ____________

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, what was the last day you worked? ____________

What type of work do you do? ____________